Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NUEVA VIDA BEHAVIORAL HEALTH AND ASSOCIATES
5555 FREDERICKSBURG RD #102
SAN ANTONIO TX 78229

Carrier's Austin Representative Box
Box Number 17

MFDR Date Received
AUGUST 19, 2013

Respondent Name
SOUTHWESTERN BELL TELEPHONE LP

MFDR Tracking Number
M4-13-3348

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…Furthermore, 99361 – Case Management- allowed to be used under the Medical Fee Guidelines for Worker's Compensation Specific Services §134.204. The rule states, 'Team conferences may occur, and be billed for, more than once every 30 days if the conferences are for the purpose of 1) coordinating return to work options with the employer, employee, or an assigned medical or vocational case manager; 2) developing or revising a treatment plan; 3) altering or clarifying previous instructions; 4) coordinating the care of employees with catastrophic or multiple injuries requiring multiple specialties.' Our documentation clearly shows this information and the purpose of the conference."

Amount in Dispute: $153.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...However, the denial of the date of service 10/31/12 this dispute remains. This medical bill was denied pursuant to a peer review as not medically necessary."

Response Submitted by: DOWNS-STANFORD, PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 24, 2012	CPT Code 90806	$125.00	$0.00
October 31, 2012	CPT Code 99361	$28.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.

2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.308 sets out the procedures for requesting review by an Independent Review Organization (IRO).
4. 28 Texas Administrative Code §133.100 sets out the procedures for health care under the treatment guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated March 4, 2013
   - 193 – Original payment decision is being maintained. This claim was process properly the first time.
   - 216 – Based on the findings of a review organization.

Issues

1. Did the requestor receive payment for date of service August 24, 2012?
2. Was the request for medical fee dispute resolution filed in accordance with 28 Texas Administrative Code §133.305 and §133.307?
3. Are the disputed services eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?

Findings

1. The requestor was contacted in regarding to the August 24, 2012 date of service. According to the insurance carrier response to this request for medical fee dispute resolution, the respondent was to make payment for the preauthorized services for this date of service. The requestor's agent was contacted and it was confirmed that the respondent paid for this date of service only. Therefore, this date of service is no longer in dispute.
2. 28 Texas Administrative Code §133.305(a)(5) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." In accordance with 28 Texas Administrative Code §133.307(f)(d)(B) requires that if the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations) and will dismiss the request in accordance with the process outlined in §133.305 of this subchapter (relating to MDR--General). The appropriate dispute process for unresolved issues of medical necessity requires the filing of a request for review by an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution. 28 Texas Administrative Code §137.100 Review of the submitted documentation finds that there are unresolved issues of medical necessity for the same service(s) for which there is a medical fee dispute. No documentation was submitted to support that the issue(s) of medical necessity have been resolved prior to the filing of the request for medical fee dispute resolution.
3. The requestor has failed to support that the services for date of service October 31, 2012 are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

Conclusion

For the reasons stated above, the requestor has failed to establish that the respondent's denial of payment reasons concerning medical necessity have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 413 prior to the submission of a medical fee dispute request for the same services. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute. As a result, no amount is ordered.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 2, 2015 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.